

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *1912*

11012

CERTIFICATE OF DEATH

Reg. Dist. No. *116*

1. PLACE OF DEATH: *Dorchester*
 County *Cambridge*
 City or town *(If outside city or town limits, write RURAL and give nearest town)*
 How long in above place of death?
 Hospital, institution, street address where death occurred: *Cambridge Maryland Hosp.*
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *MD* County *McCombs*
 City or town *Mandela Springs*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *(If rural, give LOCATION)*
 2.(a) If veteran, name war *✓*

3. (a) FULL NAME *Nathaniel Oakland Austin*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*
 6. (b) Name of husband or wife *Margaret Rutledge Austin*
 6. (c) If alive, give age *58* years
 7. Birth date of deceased (mo., day, yr.) *Oct. 19 - 1878*

8. AGE: Years *67* Months *1* Days *5* It less than one day *hrs. min.*

9. Birthplace *Atlee Maryland*
 (Town, county, and state)
 10. Usual occupation *Farmer*

11. Industry or business

12. Name *Edward Long Austin*

13. Birthplace *McCombs G. Md.*

14. Maiden name *Patty Bosler*

15. Birthplace *McCombs G. Md.*

16. Informant *Mrs. M. Rutledge Austin*
 Address *Mandela Spring Maryland*

17. Burial, cremation, or removal. Which? *Burial* Date thereof *Nov. 28 - 1945*
 (month) (day) (year)
 Cemetery or crematory *Mandela Cemetery*

Location *Mandela Maryland*

18. Funeral director *Hollman & G. Walter R. Hollman*
 Address *Selkirk Maryland*

19. *11/26/45* John Macfarlane
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *NOVEMBER 24* 19 *45* at *10:35 P.* M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *Sept. 10* 19 *45* to *Nov. 24* 19 *45*.
 and that I last saw him alive on *NOVEMBER 24* 19 *45*.

Immediate cause of death *MYOCARDIAL FAILURE* DURATION *3 days*

Due to *HYPERTENSION* ?
CHRONIC NEPHRITIS

Due to *URINARY TRACT OBSTRUCTION*
DUE TO RENAL CALCULI

Other conditions *HEMATURIA*

(Include pregnancy within 3 months of death)

Major findings of operations *BLADDER CALCULI*

Autopsy results *Physician: Please underline the cause to which death should be charged statistically.*

22. VIOLENCE: If death was due to external causes, fill in the following: *No*
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE *J. J. Blum*

Address *Cambridge Md.* M. D. or other *11/24/45*
 Date signed

RECEIVED
NOV 27 1945
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 34

CERTIFICATE OF DEATH

 11013 290116
 Reg. Dist. No.

1. PLACE OF DEATH:

County Dorchester
 City or town Cambridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs. 2 mos. 13 days
 Hospital, institution, or street address where death occurred:
Eastern Shore State Hospital
 How long in hospital or institution? 2 yrs. 2 mos. 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town Easton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 128 S. Aurora Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Lillian Beatty

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
<u>Female</u>	<u>White</u>	<u>Married</u>	
B. (b) Name of husband or wife <u>Henry Beatty</u>			
B. (c) If alive, give age <u>Unknown</u> years			
7. Birth date of deceased (mo., day, yr.) <u>July 6, 1874</u>			
8. AGE:	Years	Months	Days
	<u>71</u>	<u>4</u>	<u>0</u>
If less than one dayhrs.min.			
9. Birthplace <u>Kansas</u> (Town, county, and state)			
10. Usual occupation <u>Housewife</u>			
11. Industry or business <u>Own home</u>			
FATHER	12. Name <u>Stewart Briggs</u>		
	13. Birthplace <u>Massachusetts</u>		
MOTHER	14. Maiden name <u>Mary Dennis</u>		
	15. Birthplace <u>New York</u>		

16. Informant Hospital records
 Address E.S.S.H., Cambridge, Maryland

17. Burial Date thereof Nov 18, 1945
 (Burial, cremation, or removal) Which? (month) (day) (year)
 Cemetery or cremator Landon Cemetery
 Location Easton, Talbot Co., Md.

18. Funeral director John D. Sullivan
 Address Easton, Md.

19. 11/18 45 N.D. Neer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 19 45 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 24 19 43 to November 6 19 45
 and that I last saw him/her alive on November 6 19 45

Immediate cause of death
Arteriosclerotic Cardio-vascular Disease
 Due to Senility

DURATION
more than 2 years

Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE Grace M. Branscombe
 Address E.S.S.H., Cambridge, Md. Date signed 11/6/45

10011

STANDARD ORGANIZATION

RECEIVED
NOV 15 1945
BUREAU V.S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

11014

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 14 Park Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Burke

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Ernest Burke

7. Birth date of

deceased (mo., day, yr.)

June 26 1882

8. AGE:

63

Years

4

Months

Days

10

If less than one day

hrs.min.

9. Birthplace

Dorchester County
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

FATHER

12. Name

Rev. Grinage

13. Birthplace

Unknown

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Beatrice Jackson

Address

Cambridge, Md

17.

Burial
(Burial, cremation, or removal. Which?)Nov 12 1945
Date thereof (month) (day) (year)

Cemetery or crematory

Waver Cemetery

Location

Cambridge, Md

18. Funeral director

W. H. St. Clair & Son

Address

Cambridge, Md.

19.

11/12/45
(Date rec'd by registrar)

18.

Dr. John Macdonald
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1945, at 8:30 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 5 1945, to November 7 1945, and that I last saw him alive on November 6 1945.

Immediate cause of death

Cerebral Hemorrhage

DURATION

12 min.

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Carroll M. A. C. M.D.

M. D. or other

Address Dr. John Macdonald Date signed 11-12-45

RECEIVED

NOV 15 1945

BUREAU V K

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9420

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:

County Dorchester
 City or town Hurlock
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Hurlock - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hurlock - East New Market Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John Henry Caphas

3. (b) Social Security Number

220-07-5352

4. Sex <u>male</u>	5. Color or race <u>Colored</u>	6.(a) Single, married, widowed, or divorced <u>married</u>
6.(b) Name of husband or wife <u>Mary S. Caphas</u>		
7. Birth date of deceased (mo., day, yr.) <u>June 25 1885</u>		
6.(c) If alive, give age <u>54</u> years		
8. AGE:	Years <u>60</u>	Months <u>4</u>
	Days <u>25</u>	It less than one dayhrs.min.

9. Birthplace Dorchester County, Maryland
 (Town, county, and state)

10. Usual occupation Day Laborer

11. Industry or business Street and Sewer Employee

12. Name Stephen Caphas

13. Birthplace Dorchester County, Maryland

14. Maiden name Laura Neal

15. Birthplace Dorchester County, Maryland

16. Informant Mrs. Mary S. Caphas

Address Hurlock, Maryland, R.F.D.

17. Burial Date thereof November 26 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory East New Market Colored Cemetery

Location East New Market, Maryland

18. Funeral director J. J. Frampton and Son

Address Federalburg, Maryland

19. Nov 24 - 1945 Charles Hartung
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1945, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....X.....19....., to.....X.....19.....

and that I last saw h.....X.....alive on.....19.....

Immediate cause of death.....

Disease of Coronary Arteries

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....(City or town).....(County).....(State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Dr. K. Shriver, Dist. Med. Exam.

M. D. or other

Address Cambridge - Md. Date signed Nov 24/45

RECEIVED

APR 25 1946

BUREAU V.H.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 Years

Hospital, institution, or street address where death occurred:

Church St.How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. Church St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Laura Brown Henry

3. (b) Social Security Number

-

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Clarence J. Henry6. (c) If alive, give age - years

7. Birth date of

deceased (mo., day, yr.) Aug. 16, 1882

8. AGE:

63 Years2 Months15 Days

If less than one day

- hrs. - min.9. Birthplace KK Princess Anne, Maryland

(Town, county, and state)

10. Usual occupation Domestic11. Industry or business Home

FATHER

12. Name George W. Brown13. Birthplace Maryland

MOTHER

14. Maiden name Ellagene Adaline Brown15. Birthplace Maryland16. Informant Miss Frances HenryAddress Church St., Cambridge, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 4, 1945

(month) (day) (year)

Cemetery or crematory Christ Church CemeteryLocation Cambridge, Maryland.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. 11-3-45
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 24 1945 to Nov. 1 1945and that I last saw her alive on Nov. 1 1945

Immediate cause of death

DIASTOLIC FAILURE

DURATION

12 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

John M. ...

M. D. or other

Address Cambridge, Md. Date signed Nov 3-45

RECEIVED

NOV 8 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of age is shown on

G 99 11-25 - 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 938

CERTIFICATE OF DEATH

11016

Reg. Dist. No. 113

1. PLACE OF DEATH: Dorchester
County.....
City or town..... Taylor's Island
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... Lifetime
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME Ada. Hooper.

3. (b) Social Security Number

4. Sex Female 5. Color or race C. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) May 6 1893

8. AGE: Years 53 Months 5 Days 1 If less than one day..... hrs. min.

9. Birthplace Taylor's Island Md.
(Town, county, and state)

10. Usual occupation..... Housewife.

11. Industry or business.....

12. Name..... William Hooper.

13. Birthplace..... Md.

14. Maiden name..... Susan Thomas.

15. Birthplace..... Md.

16. Informant..... Elsie Hooper.

Address..... Taylor's Island Md.

17. Buried Date thereof..... 11-11-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cemeterys

Location..... Taylor's Island.

18. Funeral director..... Walter A. Henry.

Address..... Cambridge

19. (Date rec'd by registrar) 19..... John R. Neill Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 7 1945 at..... 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... Nov 7 1945 to..... Nov 7 1945

and that I last saw him alive on..... Nov 7 1945

Immediate cause of death.....

Due to..... Coronary thrombosis.

Due to..... Myocardial infarction.

Due to..... Arteriosclerosis.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Alfred E. Hunter, M.D.

Address..... Cambridge Md. Date signed..... 11-9-45

Wm Hopper
Susan Thomas
May 6 - 1892

1892

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1950

CERTIFICATE OF DEATH

Reg. Dist. No. 11017 116

1. PLACE OF DEATH:
 County Dorchester
 City or town Vienna (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? none
 Hospital, institution, or street address where death occurred:
road nr Henry's Cross Roads
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Dorchester
 City or town Cambridge (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Griffith's Neck
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME Theodore Hooper 3.(b) Social Security Number

4. Sex male 5. Color or race colored 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.) May 13, 1906 6.(c) If alive, give age..... years
 8. AGE: Years 39 Months 8 Days 12 If less than one day..... hrs. min.

9. Birthplace Maryland
 (Town, county, and state)
 10. Usual occupation Laborer
 11. Industry or business Farms
 12. Name Samuel Hooper
 13. Birthplace Maryland
 14. Maiden name Tina Gardner
 15. Birthplace Maryland

16. Informant Charles Horseman
 Address Vienna, Md.
 17. Burial Date thereof 11/29/45
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cross Roads Cemetery
 Location Cambridge, Maryland
 18. Funeral director Lewis A. Harrison
 Address Cambridge, Md.
 19. 11/28 19 45 John Macfarland
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 19 45 at 3-15P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
X 19..... to X 19.....
 and that I last saw h. X alive on X 19.....
 Immediate cause of death Suffocation DURATION X
 Due to fall from bicycle into mud and
water in ditch
 Due to Epileptic Spasm
 Other conditions Epilepsy 10-12 yr.
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide accident Date of Nov. 25, 45
 Where did injury occur? Vienna Dor. Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) on county road
 Means of injury Suffocation Injured at work? no
 23. SIGNATURE J. K. Shriver
Dep. Med. Exam.
 Address Cambridge, Md. Date signed Nov. 26/45

NOV 30 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1250

CERTIFICATE OF DEATH



Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Cambridge Maryland HospitalHow long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Vernon

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mary J JacksonAug 20 1904 6. (c) If alive, give age 38 years

T. Birth date of deceased (mo., day, yr.)

8. AGE: Years 41 Months Days If less than one day hrs. min.9. Birthplace Cambridge Md
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Robert Jackson13. Birthplace Cambridge Md14. Maiden name Henrietta Stanley15. Birthplace Airey Md16. Informant Mary JacksonAddress Wells St Cambridge Md17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Nov 11-45
(month) (day) (year)Cemetery or crematory CemeteryLocation Washing ton St18. Funeral director Lewis H. BaileyAddress Washington St19. 11-8- 19. 45 John M. Jackson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7th 19. 45 at 8:45 P. MI CERTIFY that death occurred on the date above stated; that I attended deceased from November 3 19. 45 to November 7 19. 45 and that I last saw him alive on November 7th 19. 45Immediate cause of death acute yellow
atrophy of liver

DURATION

2 1/2 weeks

Due to

Due to

Other conditions obesity

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edridge H. Wells M. D. or otherAddress Cambridge Md Date signed 11-7-45

RECEIVED
NOV 12 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

CERTIFICATE OF DEATH

Reg. Diat. No. 116

1. PLACE OF DEATH:

County..... Dorchester
 City or town..... Church Creek
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... entire life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... md County..... Dor.
 City or town..... Church Creek
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... none
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... none

3. (a) FULL NAME

Mary Colston Jones

3. (b) Social Security Number

none

4. Sex..... Female 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... married
 6. (b) Name of husband or wife..... Leon V. Jones
 7. Birth date of deceased (mo., day, yr.)..... Jan 16 - 1887 6. (c) If alive, give age..... 59 years

8. AGE: Years..... 58 Months..... 10 Days..... 14 If less than one day..... hrs. min.

9. Birthplace..... Church Creek
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

12. Name..... John M. Colston
 13. Birthplace..... Dor. Co.

14. Maiden name..... Adelle Graham
 15. Birthplace..... Dor. Co.

16. Informant..... Leon V. Jones
 Address..... Church Creek

17. Burial Date thereof..... 12-2-45
 (Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory..... Old Smith
 Location..... Church Creek

18. Funeral director..... Kenneth R. Thomas
 Address..... Cambridge, Md.

19. 19.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 30 1945 at 1:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 to May 1945

and that I last saw her alive on May 1945

Immediate cause of death..... DURATION

Hypertensive Cardio-vascular remodeling 10 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... L. O. Meredith M. D. or other

Address..... 28 Poplar Street, Cambridge, Md. Date signed..... Dec. 2, 1945

RECEIVED

DEC 4 1945

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11020

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester Co
City or town Hannsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Hannsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name War

3. (a) FULL NAME

May Augusta Richards Cyphus Kane

3. (b) Social Security Number

4. Sex female 5. Color or race colored 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife David Kane
7. Birth date of deceased (mo., day, yr.) May 7 1894
6.(c) If alive, give age 64 years

8. AGE: Years 61 Months 6 Days 17 It less than one day
hrs. min.

9. Birthplace Daguer Island
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Lister Cornish

15. Birthplace Maryland

16. Informant David Kane

Address Hannsville Md

17. Burial Date thereof 11/28/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Madison Cemetery

Location Madison Maryland

18. Funeral director Lewis H. Bayne

Address Cumtux Maryland

19. 11/28/45 John Macgregor Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1945 at 12:53 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 31 1945 to November 24 1945 and that I last saw him alive on Nov 20 1945

Immediate cause of death Carcinoma Uterus DURATION 7 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Operation John Hopkins

Baltimore Md Date of op. May 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

SIGNATURE Carol M. Steele MD M. D. or other

Address Baltimore Md Date signed 11-26-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

REC

NOV 30 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 361

CERTIFICATE OF DEATH

11021

Reg. Dist. No. 116

1. PLACE OF DEATH. Dorchester

County.....

City or town..... Cambridge,
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 1 year - 8 days

Hospital, institution, or street address where death occurred:

Eastern Shore State HospitalHow long in hospital or institution?..... 1 year - 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... CarolineCity or town..... Ridgley
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)2.(a) If veteran, name war..... Unknown ✓

3. (a) FULL NAME

Theodore Kershaw

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

MaleWhiteWidower6. (b) Name of husband or wife..... Unknown7. Birth date of deceased (mo., day, yr.)..... 1855 6. (c) If alive, give age..... years8. AGE: Years..... 90 Months..... 5 Days..... 21 If less than one day..... hrs. min.9. Birthplace..... Lancaster County, England
(Town, county, and state)10. Usual occupation..... Painter and Paper Hanger

11. Industry or business

12. Name..... Unknown13. Birthplace..... England14. Maiden name..... Unknown15. Birthplace..... Unknown16. Informant..... Hospital RecordsAddress..... E.S.S. Hospital. Cambridge, Maryland.17. Burial Date thereof..... 11-4-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Denton CemeteryLocation..... Denton, Md.18. Funeral director..... E. L. LaneAddress..... church Hill M.D.19. 11-1-45 1945 John Mace Jr. M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 1st. 1945 at 4:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 24, 1944 to November 1, 1945
and that I last saw him alive on October 31st. 1945Immediate cause of death.....
Arteriosclerosis cardio-vascular
disease DURATION..... unknownDue to.....
SenilityDue to.....
Other conditions..... Emphysema
Senile Psychosis 2 yrs
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Grace M. Branscombe M. D. or other
Address..... E.S.S. Hospital, Cambridge Date signed 11-1-45

RECEIVED

NOV 5 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md

CERTIFICATE OF DEATH

11022

Reg. Dist. No. 111

1. PLACE OF DEATH

County Dorchester
 City or town East New Market
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Fred C. Knasek

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white Widower

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Sept 10 18648. AGE: Years Months Days If less than one day
81 4 18 hrs. min.9. Birthplace Germany
(Town, county and state)10. Usual occupation Farmer11. Industry or business Farming12. Name Mrs Knasek13. Birthplace Germany14. Maiden name Lekha Straki15. Birthplace Germany16. Informant John G. GaderAddress East New Market17. Burial Date thereof Nov 29 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CemeteryLocation East New Market18. Funeral director H. H. ThibaultAddress East New Market19. Nov 29 1945 per Elizabeth C. Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1945 at 5 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1944 to Nov 28 1945
 and that I last saw him alive on Nov 26 1945

Immediate cause of death Thromb.
Valvular disease

DURATION

2

Due to.....

Due to.....

Other conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. H. Thibault M. D. or otherAddress East New Market Date signed 11/29/45

RECEIVED
DEC 7 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

11023

Reg. Diat. No. 111

1. PLACE OF DEATH:

County RockesterCity or town East New Market.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

Mary Anne Krueger

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife: _____

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

Oct 19th 1861

8. AGE:

Years

Months

Days

If less than one day

8417

hrs.

min.

9. Birthplace

Germany.
(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

Same

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 28 1945 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 1st 1944 to November 28th 1945

and that I last saw him/her alive on

Nov 28 1945

Immediate cause of death

Chronic myocardial degeneration

DURATION

1 yr +

Due to

General arteriosclerosis5 yrs +

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William E. Harrison MD

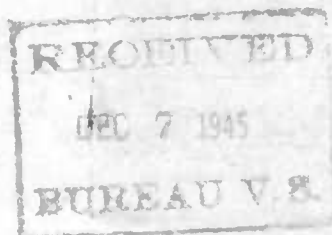
M. D. or other

Address

Hurlock Md.

Date signed

12/30/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17003

CERTIFICATE OF DEATH

11024

Reg. Dist. No. 116

1. PLACE OF DEATH: **Dorchester**
 County.....
Cambridge
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **1 Day**
 Hospital, institution, or street address where death occurred:
Cambridge-Maryland Hospital
 How long in hospital or institution? **1 Day**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State **Maryland** County **Talbot**
 City or town **Easton**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **Rural**
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ✓

3. (a) FULL NAME
Margaret Bayhan Marvel

3. (b) Social Security Number
none

4. Sex **Female** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Married**
 6. (b) Name of husband or wife **A.E. Marvel**
 7. Birth date of deceased (mo., day, yr.) **May 11, 1897**
 6. (c) If alive, give age **50** years
 8. AGE: Years **48** Months **6** Days **0** If less than one day
hrs.min.

9. Birthplace **Easton, Md.**
 (Town, county, and state)
 10. Usual occupation **Homemaker**
 11. Industry or business

FATHER 12. Name **O.W. Bayhan**
 13. Birthplace **Illinois**
 MOTHER 14. Maiden name **Alverta Jeannette Eaton**
 15. Birthplace **Maryland**

16. Informant **Frank Benny**
 Address **Easton, Md.**

17. Burial **Burial** Date thereon **Nov. 14, 1945**
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory **Spring Hill Cemetery**
 Location **Easton, Md.**

18. Funeral director **R. Ellis Clark**
 Address **Easton, Md.**

19. **Nov. 13-45** **John Marvel**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **November 11** 19 **45**, at **2-55P** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
X 19..... to **X** 19.....

and that I last saw h. **X** alive on **X** 19.....

Immediate cause of death..... DURATION

Pulmonary Embolism **Nov. 11**

Due to.....
Head and Chest injuries **Nov. 10**

Due to.....

Other conditions **Hypertension- Cardio-vascular Disease, Shock**
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide **accident** Date of **Nov. 10/45**
 Where did injury occur? **near Cambridge, Dor. Md.**
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) **on State Road**

Means of Injury **automobile** Injured at work? **no**

23. SIGNATURE: **J. K. Shriver, Dep. Med. Exam.**
 M. D. or other
 Address **Cambridge, Md.** Date signed **Nov. 12/45**

RECEIVED
NOV 15 1945
BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11025 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred:
Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. 317 Locust street
(If rural, give LOCATION)2. (a) If veteran, name war X

3. (a) FULL NAME

BEULAH MOORE MATTHEWS.

3. (b) Social Security Number

X

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married8. (b) Name of husband or wife Robert H. Matthews6. (c) If alive, give age 61 years7. Birth date of deceased (mo., day, yr.) 8/26/18868. AGE: Years 59 Months 2 Days 14 It less than one day
hrs. min.9. Birthplace Cambridge, Md.
(Town, county, and state)10. Usual occupation Domestic.11. Industry or business none12. Name Father W. Moore13. Birthplace Maryland.14. Maiden name Martha E. Moore.15. Birthplace Maryland18. Informant Robert H. Matthews.Address Cambridge, Md.,17. Burial Date thereof 11/14/45.
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenlawn cemetery.Location Cambridge, Md.18. Funeral director LeCompte Funeral Service.Address Cambridge, Md.,19. 11/17/45 John Moore Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November, 10, 1945 at 4:00 P.M.21. I CERTIFY that death occurred on the date above stated that I attended deceased from
June 10, 1945 to November 10, 1945
and that I last saw him alive on NOVEMBER 10, 1945Immediate cause of death
Metastatic carcinoma from descending colon
adenocarcinomaDUE TO
Due to
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations adenocarcinoma desc. colon Date of op.Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following: none.
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Moore Jr. M. D. or other
Cambridge Md Date signed 11/14/45
Address

RECEIVED

NOV 21 1945

BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore/44-2

11026

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

Cambridge Maryland HospitalHow long in hospital or institution? 12 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)Street No. R 78 #0
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Louise Nelson

3. (b) Social Security Number

4. Sex

female

5. Color or race

Calab

6. (a) Single, married, widowed, or divorced

widow6. (b) Name of husband or wife William Nelson

7. Birth date of

deceased (mo., day, yr.)

Feb 21 19046. (c) If alive, give age 40 years

8. AGE:

Years

Months

Days

If less than one day

49

hrs.

min.

9. Birthplace

Cambridge
(Town, county, and state)

10. Usual occupation

Lab-er

11. Industry or business

none

12. Name

Bengman nicholas

13. Birthplace

md

14. Maiden name

Lizziel Calab

15. Birthplace

Church Creek

18. Informant

same

Address

Cambridge md11. Nov 11

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Rock

Location

near Cambridge

18. Funeral director

Louis H. Barnes

Address

Cambridge md19. 11/11/45

(Date rec'd by registrar)

19. 4519. 4519. 4519. 4519. 4519. 4519. 4519. 4519. 4519. 4519. 4519. 4519. 4519. 4519. 4519. 4519. 4519. 45

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1945 at 11 M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

11/7 1945 to 11/8 1945and that I last saw him alive on 11/8 1945

Immediate cause of death

Dilatation of heartDue to myocardial failureDue to hepatic toxemiaOther conditions of pregnancy

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Cambridge md

Address

Date signed 11/10/45

RECORDED

NOV 15 1945

BUREAU V M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

CERTIFICATE OF DEATH

Reg. Dist. No. 11027 110113

1. PLACE OF DEATH:

County DorchesterCity or town Rural - Taylors's Island
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Rural-Taylors IslandHow long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Rural-Taylors Island
(If outside city or town limits, write RURAL and give nearest town)Street No. Taylors Island
(If rural, give LOCATION)2.(a) If veteran, name war -

3. (a) FULL NAME

Joseph McCellan North

3. (b) Social Security Number

-

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Margaret Elizabeth Brown
Deceased Feb. 1936

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) Aug. 1, 1868

8. AGE:

Years

Months

Days

If less than one day

773-

hrs.

min.

9. Birthplace Taylors Island, Dor. Co., Md.
(Town, county, and state)10. Usual occupation Carpenter (Retired)

11. Industry or business

Ship

FATHER

12. Name

Not Known

13. Birthplace

""

MOTHER

14. Maiden name

Not Known

15. Birthplace

""16. Informant Earl Ward HughesAddress Taylors Island, Md.17. Burial Date thereof Nov. 4, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Brick Church CemeteryLocation Taylors Island, Maryland18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. Nov. 4 19 45
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1945 at 10: A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

Gunshot wound
through left chest

DURATION

immediate

Due to

Self-inflicted

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of Nov. 1/45Where did injury occur? Taylors Island, Dor. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) at homeMeans of injury Shot gun Injured at work? no

Dr. B. Sprin, Dep. Med. Comm.

23. SIGNATURE Cambridge - Md. M. D. or otherAddress Cambridge - Md. Date signed Nov. 5/45

RECEIVED

DEC 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11028

★ Reg. Diat. No. 110

1. PLACE OF DEATH:

County DorchesterCity or town Williamsburg - Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Near Hyson

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Williamsburg - Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Near Hyson
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Joseph M. Paul

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Sarah Frances Paul6.(c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) November 8, 18518. AGE: Years 94 Months 0 Days 13 It less than one day
.....hrs.min.9. Birthplace Dorchester County, Maryland
(Town, county, and state)10. Usual occupation Retired Farmer11. Industry or business Farm12. Name Levin Paul13. Birthplace Dorchester County, Maryland14. Maiden name Mary Ford15. Birthplace Dorchester County, Maryland16. Informant Albert K. PaulAddress Williamsburg, Maryland, R.F.D.17. Burial Date thereof November 23, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Washington CemeteryLocation Near Hubert, Maryland18. Funeral director J. J. Frampton and SonAddress Federalburg, Maryland19. Nov 23 19 45 Chas W Hastings
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 19 45, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 10, 19 45, to Nov 21, 19 45and that I last saw him alive on Nov 20, 19 45Immediate cause of death Spontaneous2 broken ribsDue to a fallDue to —Other conditions —

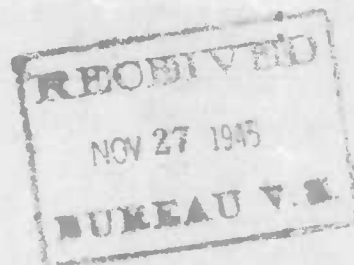
(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Antopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? at his home on R. rd.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury accidently fell Injured at work? no23. SIGNATURE L. L. ArgerAddress Hubert, Md.Date signed Nov 23-45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27

CERTIFICATE OF DEATH

Reg. Dist. No. 11029 110

1. PLACE OF DEATH:

County Dorchester
City or town Hurlock
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 day
Hospital, institution, or street address where death occurred Taylor Ave (R.F.D.) #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED;

(For newborn infants give residence of mother)
State Md. County McComie
City or town Mandela
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

William J. Pollitt

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Alice Field Pollitt

7. Birth date of deceased (mo., day, yr.) Mo. Record July 8-1869 6.(c) If alive, give age Dead years

8. AGE: Years 76 Months 4 Days 2 If less than one day _____ hrs. _____ min.

8. Birthplace Mantoloking, Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farmer

12. Name Thomas Pollitt

13. Birthplace Mantoloking, Md.

14. Maiden name Amelia Byrd

15. Birthplace Mantoloking, Md.

16. Informant Mrs. Adam Pomee

Address P.O. #1, Hurlock, Md.

17. Burial Date thereof Nov. 13-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mandela, Md.

Location Mandela, Maryland

18. Funeral Director Wm. G. Waller R. Waller

Address Salisbury, Maryland

19. Nov 12 - 1945 Registrar Charles Hastings

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1945, at 5 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5 1945 to Nov. 10 1945

and that I last saw him alive on Oct. 28 1945

Immediate cause of death Coronary Artery Disease

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____ Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work?

23. SIGNATURE Dr. J. J. J. J. M. D. or other

Address _____ Date signed 11-12-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REC

DEC 10

RECEIVED

BURE

DEC 10 1948

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1212

CERTIFICATE OF DEATH

Reg. Dist. No. 112

1. PLACE OF DEATH:

County..... Dorchester
 City or town..... Vienna, R.D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 91 years.
 Hospital, institution, or street address where death occurred: None.
 How long in hospital or institution?..... No Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland. County..... Dorchester.
 City or town..... Vienna, R.D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... No street.
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... No veteran.

3. (a) FULL NAME

George Thomas Ralph.

3. (b) Social Security Number

None.

4. Sex..... Male. 5. Color or race..... White. 6.(a) Single, married, widowed, or divorced..... Single.
 6.(b) Name of husband or wife..... No husband or wife.
 6.(c) If alive, give age..... 0 years
 7. Birth date of deceased (mo., day, yr.)..... October 13th., 1854.
 8. AGE: Years..... 91 Months..... 0 Days..... 26 If less than one day..... hrs. min.

9. Birthplace..... Mardela Springs, Maryland.
Wicomico County. (Town, county, and state)
 10. Usual occupation..... Farmer.

11. Industry or business..... Farming.

FATHER 12. Name..... Thomas Samuel Ralph.
 13. Birthplace..... Laurel, Delaware.

MOTHER 14. Maiden name..... Nancy Weatherly.
 15. Birthplace..... Hebron, Maryland. R.D.

18. Informant..... Mrs. Walter (Doris) Ralph.
 Address..... Vienna, R.D., Maryland.

17. Burial. Date thereof..... Nov. 10" 1945
 (Burial, cremation, or removal, Which?)..... (Month, day) (year)
 Cemetery or crematory..... Mardela Springs Md.
 Location..... Cemetery, Mardela Springs, Md.

18. Funeral director..... Willoughby & Son.
 Address..... East New Market, Maryland.

19. Nov 9 19. 45-
 (Date rec'd by registrar)

Eliabell R. R. Local
 Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... November 8th., 1945. at 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct. 31" 1945 to Oct. 31" 1945
 and that I last saw him alive on Oct. 31" 1945.

Immediate cause of death..... Uraemia.

| | DURATION |
|---------------------------------------|--------------|
| Due to..... <u>Chronic Nephritis.</u> | <u>4 Yrs</u> |

Due to.....
 Other conditions..... Cystitis, Constipation. 7 Yrs
Oedema of extremities, Coronary 1 Yr.
fibrillation. (Include pregnancy within 3 months of death)

Major findings of operations..... No operation.
No findings. Date of op. No date.

Autopsy results..... No autopsy.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... No violence, No suicide.
 Where did injury occur?..... Nothing occurred.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... Nowhere.Means of injury..... No injury, no murder, no work.

23. SIGNATURE..... Edward E. Lamkin
Edward E. Lamkin, M.D. M.D. or other
 Address..... Vienna, Maryland. Date signed..... 11/8/45

RECEIVED
NOV 12 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13/2

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester

City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

313 Talbot Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)

Street No. 313 Talbot Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret Ann Phillips Shannahan

3. (b) Social Security Number

-

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife William Shannahan
(Deceased)

7. Birth date of deceased (mo., day) Aug. 20. 1856.

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
89 2 28 hrs. min.

9. Birthplace Laurel, Delaware
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Phillips

13. Birthplace Delaware

MOTHER 14. Maiden name Phyllis Hearn

15. Birthplace Delaware

16. Informant Mrs. William Brohawn

Address 313 Talbot Ave., Cambridge, Md

17. Burial Date thereof Nov. 20, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cambridge Cemetery

Location Cambridge, Maryland.

18. Funeral director LeCompte's Funeral Service
Cambridge, Maryland.

Address

19. 11/20 19 45 John MacFarland
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1945 at 9: A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 5 19 42, to November 18, 1945
and that I last saw her alive on Nov 16th 19 45

Immediate cause of death

Cerebral Embolus

DURATION

3 days

Due to Arteriosclerotic Cardiovascular Renal Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Eldridge H. Belford
M.D. or other
Address Cambridge Md. Date signed 11-19-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11031

NOV 26 1945

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

CERTIFICATE OF DEATH

11032

Reg. Dist. No. 116

1. PLACE OF DEATH:

County DorchesterCity or town Aisay
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Aisay
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Jonathan StandleySex Male5. Color or race White6. (a) Single, married, widowed, or divorced Widower6. (b) Name of husband or wife Louise Standley7. Birth date of deceased (mo., day, yr.) 1896

6. (c) If alive, give age _____ years

8. AGE: Years 49 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Bucktown
(Town, county, and state)10. Usual occupation Laborer11. Industry or business None12. Name James Standley13. Birthplace MD14. Maiden name Mary Standley15. Birthplace MD16. Informant unidentified BrookAddress Aisay17. Dec 2 1945 Date thereof Burial
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BucktownLocation Bucktown18. Funeral director Louis H. BaymenAddress Cambeltown19. Dec 2 1945 (Date rec'd by registrar) Registrar John Macfarlane

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1945 at 4:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 20 1945 to Nov 30 1945
and that I last saw him alive on Nov 20th 1945

Immediate cause of death

Cerebral accident

DURATION

1 1/2 days

Due to

arteriosclerotic CVD
(Cardiovascular disease)2 yrs +

Due to

Other conditions Insanitary, old age
undetermined
(Include pregnancy within 3 months of death)2 weeks

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

Eldridge H. Hoffland
Cambeltown, MD Date signed Dec 2 1945

RECEIVED
DEC 7 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

CERTIFICATE OF DEATH

Reg. Dist. No. 110220

1. PLACE OF DEATH:

County Dorchester
 City or town Federalistburg - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 53 years
 Hospital, institution, or street address where death occurred:
Peston Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Dorchester
 City or town Federalistburg - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Peston Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mary Alice Todd

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Thomas J. Todd6. (c) If alive, give age 77 years

7. Birth date of

deceased (mo., day, yr.)

February 5, 1870

8. AGE:

Years

75

Months

9

Days

12

If less than one day

.....hrs.

.....min.

9. Birthplace

Caroline County, Maryland
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

None

FATHER

12. Name

Robert R. Edgell

13. Birthplace

Caroline County, Maryland

MOTHER

14. Maiden name

Nancy Todd

15. Birthplace

Caroline County, Maryland

16. Informant

Thomas J. Todd

Address

Federalistburg, Maryland, RFD.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

November 20 1945
(month) (day) (year)

Cemetery or crematory

High Crest Cemetery

Location

Federalistburg, Maryland

18. Funeral director

J. J. Thompson and Son

Address

Federalistburg, Maryland

19. Nov 20

(Date rec'd by registrar)

19

45

Chas W. Todd

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1945 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov 17th 1945, to Nov 17th 1945
 and that I last saw her alive on Nov 17th 1945

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 yr.

Due to

Hypertension & myocardial3 yr.

Due to

Other conditions

Acute Pulmonary Edema 6 hr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank M. Anderson M.D.

M. D. or other

Address Federalistburg, Md. Date signed 11/20/45

RECEIVED

NOV 27 1945

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93D

CERTIFICATE OF DEATH

11034
Reg. Dist. No. 116

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH:
County..... <u>Dorchester</u>
City or town..... <u>Cambridge</u>
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? <u>2 years - 4 months 3 days</u>
Hospital, institution, or street address where death occurred:
<u>Eastern Shore State Hospital</u>
How long in hospital or institution? <u>2 years - 4 months - 3 days</u> | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... <u>Maryland</u> County..... <u>Wicomico</u>
City or town..... <u>Salisbury</u>
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war..... | | | |
| 3. (a) FULL NAME
<u>Raymond Willard Truitt</u> | | | | 3. (b) Social Security Number | | | |
| 4. Sex
<u>Male</u> | | 5. Color or race
<u>White</u> | | 6. (a) Single, married, widowed, or divorced
<u>Single</u> | | | |
| B. (b) Name of husband or wife | | | | | | | |
| 7. Birth date of deceased (mo., day, yr.) <u>February 13, 1922</u> | | | | | | | |
| 8. AGE: Years <u>23</u> | | Months <u>-</u> | | Days <u>-</u> | | If less than one day
..... hrs. min. | |
| 9. Birthplace <u>Pittsville, Wicomico County, Maryland</u>
(Town, county, and state) | | | | | | | |
| 10. Usual occupation <u>Farmer</u> | | | | | | | |
| 11. Industry or business | | | | | | | |
| FATHER | | 12. Name <u>Preston George Truitt</u> | | | | | |
| MOTHER | | 13. Birthplace <u>Pittsville, Wicomico County, Maryland</u> | | | | | |
| 14. Maiden name <u>Edith Ellen Tingle</u> | | 15. Birthplace <u>Delmar, Delaware</u> | | | | | |
| 16. Informant <u>Hospital Records</u>
Address <u>E.S.S. Hospital, Cambridge, Maryland</u> | | | | | | | |
| 17. Burial <u>Burial</u> Date thereof <u>11-29-45</u>
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory <u>Delmar</u>
Location <u>Delmar</u> | | | | | | | |
| 18. Funeral director <u>M. S. Grand Co.</u>
Address <u>Delmar Delaware</u> | | | | | | | |
| 19. <u>11-29-</u> <u>19 45</u> <u>John Macfarlane</u>
(Date rec'd by registrar) Registrar | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| 20. DATE OF DEATH <u>November 27th</u> 19 <u>45</u> at <u>1:25 P.M.</u> | | | | | | | |
| 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>July 24</u> 19 <u>43</u> to <u>November 27</u> 19 <u>45</u>
and that I last saw him alive on <u>November 27</u> 19 <u>45</u>
Immediate cause of death <u>Bronchopneumonia, terminal</u>
<u>Chronic myocarditis</u>
DURATION
<u>1 day</u>
<u>3 mos. ?</u> | | | | | | | |
| Due to.....
Due to.....
Other conditions <u>Extreme obesity, pilonidal cyst</u>
(Include pregnancy within 3 months of death) | | | | | | | |
| Major findings of operations.....
Date of op. | | | | | | | |
| Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically. | | | | | | | |
| 22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work? | | | | | | | |
| 23. SIGNATURE <u>Grace M. Branscombe</u>
<u>E.S.S.H., Cambridge, Md.</u> Date signed <u>11/27/45</u> | | | | | | | |

RECEIVED

DEC 4 1945

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

Reg. Dist. No. 11035 115

1. PLACE OF DEATH:
County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 days
Hospital, institution, or street address where death occurred:
Eastern Shore State Hospital
How long in hospital or institution? 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Hoopersville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Edwin C. Tyler

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Minnie Parks
6.(c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) December 8, 1872
8. AGE: Years 72 Months 11 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Hoopersville, Dorchester Co., Md.
(Town, county, and state)
10. Usual occupation Unknown - Sign Home Keeper
11. Industry or business U.S. Coast Guard

FATHER
12. Name James Tyler
13. Birthplace Hoopersville, Maryland
MOTHER
14. Maiden name Susan M. Tyler
15. Birthplace Hoopersville, Maryland

16. Informant Hospital Records
Address E.S.S.H., Cambridge, Maryland
17. Burial Date thereof Nov. 25, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Family Cemetery
Location Hoopersville, Maryland

18. Funeral director LeCompte's Funeral Service
Address Cambridge, Maryland

19. Dec 12 19 45 James W. Munde
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 19 45, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 26 19 45, to November 22 19 45
and that I last saw him alive on November 22, 19 45

Immediate cause of death Cerebral hemorrhage DURATION 2 days

Due to _____

Due to _____

Other conditions Senility Unk.

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE _____

Grace M. Branscombe, M.D. M. D. or otherAddress E.S.S.H., Cambridge, Md. Date signed 11/23/45

RECEIVED
DEC 14 1945
BUREAU V.E.

RECEIVED

NOV 21 1945

BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore MD

CERTIFICATE OF DEATH

Reg. Dist. No. 1B

1. PLACE OF DEATH:

County.....Dorchester
 City or town.....Church Creek
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....Life
 Hospital, institution, or street address where death occurred:
Home-Church Creek
 How long in hospital or institution?.....-

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Dorchester
 City or town.....Church Creek
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....Church Creek
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....-

3. (a) FULL NAME

Emma Richardson Willis

3. (b) Social Security Number

-

4. Sex.....Female 5. Color or race.....white 6.(a) Single, married, widowed, or divorced.....Widowed
 8.(b) Name of husband or wife.....George W. Willis
 (Deceased) 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.).....Feb. 17, 1866.
 8. AGE: Years.....79 Months.....8 Days.....22 If less than one day..... hrs. min.

8. Birthplace.....Church Creek, Dor. Co., Md.
 (Town, county, and state)
 10. Usual occupation.....Domestic
 11. Industry or business.....Home

FATHER 12. Name.....Levin H. Richardson
 13. Birthplace.....Maryland
 MOTHER 14. Maiden name.....Hester Richardson
 15. Birthplace.....Maryland

18. Informant.....Mrs. C. E. Brannock
 Address.....Church Creek, Maryland.

17. Burial.....Burial Date thereof.....Nov. 18, 1945
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory.....old Trinty Cemetery
 Location.....Church Creek, Maryland

18. Funeral director.....LeCompte's Funeral Service
 Address.....Cambridge, Maryland.

19. 11/14 1945 John Mace Jr. M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....November 9, 1945 at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 7, 1945 to Nov. 9, 1945
 and that I last saw him alive on Nov. 9, 1945

Immediate cause of death.....Patent Pericarditis
 DURATION.....2 d.

Due to.....
 Due to.....
 Other conditions.....Chronic myocarditis 4 years
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE.....P. H. Tarrance M. D. or other
 Address.....Cambridge, Md. Date signed 11/12/45

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NOV 16 1945

BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No. 115

1. PLACE OF DEATH:

County Dorchester
City or town Wingates
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Home - Wingates
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
City or town Wingates
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural - Wingates
(If rural, give LOCATION)
2. (a) If veteran, name war -

3. (a) FULL NAME

William H. Windsor

3. (b) Social Security Number

-

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced XXXXXX Widowed

6. (b) Name of husband or wife Annie Adams
(Deceased - 1934) B. (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1868

8. AGE: Years 77 Months 2 Days - If less than one day - hrs. - min.

9. Birthplace Toddville, Dor. Co., Md.
(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business II

12. Name Thomas Windsor

13. Birthplace Maryland

14. Maiden name Not Known

15. Birthplace II II

16. Informant Mr. W. J. Windsor

Address Wingates, Maryland.

17. Burial Date thereof Nov. 26, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Adams Cemetery

Location Wingates, Maryland.

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. Dec 14 19 45 Wilson & Ritchie
(Date rec'd by registrar) (month) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1945 at 3:25 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1945, to Sept 4 1945, and that I last saw him alive on Sept 4 1945

Immediate cause of death arterio-sclerosis

DURATION

2 yrs

Due to -

Due to -

Other conditions -

(Include pregnancy within 8 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE C. H. Towner M. D. or other -

Address Cambridge, Md. Date signed 11/29/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11038

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JAN 3 1946

RECEIVED

JAN 3 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

CERTIFICATE OF DEATH

11039

Reg. Dist. No. 116

1. PLACE OF DEATH:

County Dorchester
 City or town Causey
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? entire life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Causey, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Maryland Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Daniel H. Wright Sr.

3. (b) Social Security Number

none

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

B. Ruth Brown6. (c) If alive, give age 65 years

7. Birth date of

deceased (mo., day, yr.)

Jan. 1st, 1876

8. AGE:

Years

69

Months

10

Days

0

If less than one day

hrs.

min.

9. Birthplace

Causey
(Town, county, and state)

10. Usual occupation

Grocery Store operator

11. Industry or business

Wm. Wright

FATHER

12. Name

Wm. Wright

13. Birthplace

Wm. Co.

MOTHER

14. Maiden name

Annex. Wherette

15. Birthplace

Wm. Co.

16. Informant

Mrs. Daniel H. Wright Sr.

Address

Causey, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Nov 3, 1945

Cemetery or crematory

Dorchester Memorial

Location

Causey, Md.

18. Funeral director

Kenneth R. Thomas

Address

Causey, Md.

19.

11-3-45
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 19 45 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 29 19 45 to Nov 1 19 45and that I last saw him alive on Oct 31 19 45Immediate cause of death rupturedartery inupper part ofstomachDue to arterystomachDue to arterystomach

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ruptured arterystomachAutopsy results planned

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City of town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John MacphersonAddress Causey, Md.

M. D. or other

Date signed 11-2-45

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NOV 8 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Diat. No. 116

11040

1. PLACE OF DEATH:

County Dorchester
 City or town Linkwood
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 years
 Hospital, institution, or street address where death occurred:
Home- Linkwood
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town Linkwood
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Linkwood
 (If rural, give LOCATION)
 2. (a) If veteran, name war -

3. (a) FULL NAME

Henry Zimmerman

3. (b) Social Security Number

-

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife Jennie Weiderhoff
 6. (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1868
 8. AGE: Years 77 Months 1 Days 10 If less than one day - hrs. - min.

9. Birthplace Hanover, Germany
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Dirt

12. Name Not Known

13. Birthplace " "

14. Maiden name Not Known

15. Birthplace " "

16. Informant Mr. Lee Zimmerman

Address Linkwood, Maryland.

17. Burial Date thereof Nov. 17, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dorchester Memorial Park

Location Cambridge, Maryland.

18. Funeral director LeCompte's Funeral Service

Address Cambridge, Maryland.

19. 11/17/45 John Macfarlane
 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1945, 11-15AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from X 19 - to X 19 -
 and that I last saw him alive on X 19 -

Immediate cause of death Disease of Coronary Arteries DURATION immediate

Due to X

Due to X

Other conditions X

(Include pregnancy within 3 months of death)

Major findings of operations X

Date of op. -

Autopsy results X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE For B. Shriver, Dep. Med. Ex.

M. D. or other

Address Cambridge, Md. Date signed Nov. 16/45

RECEIVED

NOV 21 1945

BUREAU V.E.